AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO USMD

Patient's full name: _____ Date of birth _____

I authorize _____ (Name of person/entity who should release records)
to release the following information by mail, fax, electronically or orally to:

USMD Physician Services

Address: _____

_____

Phone: _____

Fax: _____

Information is for:

☐ Dr. _____

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. A photocopy or fax of this authorization is as valid as this original.
2. I may revoke this authorization at any time in writing, except where information has already been released.
3. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
4. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above